Commonwealth of Virginia
Department of Social Services

Neighborhood Assistance Program
Services Contribution Data Sheet

(PRINT)

To Be Used For Donated Pharmacy Services provided at a 501©3 Clinic at the direction of an approved NAP Organization

(Please use a separate form for each clinic)

NAME OF DONOR: _____

ADDRESS: _____

NAME OF NAP ORGANIZATION_____

Contact Info Of Clinic Where Services Were Provided	**DATE** (List each date separately)	**HOURLY RATE** (excludes fringes)	**TOTAL HOURS WORKED**	**TOTAL VALUE** (Rate x Hours)
Federal ID#_____ _____ Name of 501©3 Clinic _____ Address of Clinic _____, VA _____ City ZIP Code _____ Phone				

NOTE: Other formats providing the same information will be accepted. Sign and attach this form to the CNF or other format and return to the NAP Organization.

CERTIFICATION BY PHARMACIST: I certify that the value of the donated service(s) was determined by the standards stated in the instructions and does not exceed the statutory maximum. I also certify I will not receive any type of compensation or reimbursement from medical insurance filing or from my company for the donated service(s) nor will my company receive any compensation. I understand that if I falsify information, I may be subject to penalties prescribed by the Virginia Departments of Taxation and Social Services.

_____ _____

Date Signature of Donor

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